STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445172	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	R **11/25/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA NURSING AND REHABILITATION-SMITH COUNTY	**112 HEALTH CARE DR** **CARTHAGE, TN 37030**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS During the follow up survey conducted on 11/25/2019, all previously cited Federal citations were corrected.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th day / 70th
11-15-19 / 12-10-19

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC#2	445172	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA NURSING AND REHABILITATION-SMITH COUNTY	112 HEALTH CARE DR CARTHAGE, TN 37030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Stories: 2 Construction Type: NFPA, III (111) Limited plans available on site Constructed: 1982 Sprinklered: Yes Certified beds: 124 Census: 91 A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulations Office of Health Care Facilities on 06/23/2019. During this Life Safety Survey, Concordia Nursing and Rehabilitation-Smith County was found not in substantial compliance with the requirements for participation in Medicare/Medicaid with Title 42 CFR Subpart 483.70(a), The Rules of Tennessee Department of Health Board for Licensing Health Care Facilities Chapter 1200-08-06 Standards For Nursing Homes, and National Fire Protection Association (NFPA) 101 Life Safety (2012 Edition).	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches	K 321	1. On 9/23/19 the Maintenance Director closed the kitchen storage room door. 2. All residents had the potential to be affected, but no residents were affected. 3. On 9/24/2019 Administrator and Director of Nursing educated the Maintenance Director and his assistant on the regulations pertaining to Hazards Areas-Enclosure. 4. Administrator and Maintenance Director will monitor compliance using an audit tool 3 X a week for 1 month, 2 X a week for 1 month, 1 X a week for an additional month. Any findings will be conveyed to the monthly QAPI meeting for 3 months.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

RECEIVED
10-24-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445172	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA NURSING AND REHABILITATION-SMITH COUNTY	112 HEALTH CARE DR CARTHAGE, TN 37030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 1 from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Separation N/A — Automatic Sprinkler a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on an observation, the facility failed to maintain hazardous areas. The finding included: Observation on 09/23/2019 at 10:06 AM, revealed the kitchen storage room door was propped open with an unapproved system. NFPA 101, 19.3.2.1.3 (2012 Edition) The maintenance director was present for the findings which were later acknowledged by the administrator during the exit conference on 09/23/2019	K 321		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance	K 324		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445172	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA NURSING AND REHABILITATION-SMITH COUNTY	112 HEALTH CARE DR CARTHAGE, TN 37030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 2 with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on an observation, the facility failed to maintain the kitchen hood suppression system. The findings included: Observation on 09/23/2019 at 10:03 AM, revealed 1 of 4 hood suppression nozzle caps were missing. NFPA 101, 19.3.2.5.3 (2012 Edition), NFPA 96, 10.2.6 (2011 Edition), NFPA 17A, 4.3.1.5 (2009 Edition) The maintenance director was present for the	K 324	1. On 9/27/2019 the Maintenance Director replaced the missing hood suppression nozzle cap. 2. All residents had the potential to be affected, but no residents were affected. 3. On 9/24/2019 Administrator and Director Of Nursing educated the Maintenance director and his assistant on the regulations pertaining to Cooking Facilities. 4. Administrator and Maintenance Director will monitor compliance by utilizing an audit tool 3 x week for 1 month, 2 x week for 1 month and 1 x week for I month. Any findings will be brought to the monthly QAPI meeting for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445172	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA NURSING AND REHABILITATION-SMITH COUNTY	112 HEALTH CARE DR CARTHAGE, TN 37030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 3 findings which were later acknowledged by the administrator during the exit conference on 09/23/2019	K 324		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to maintain the fire sprinkler system. The findings include: 1. Document review on 9/23/2019 between 9:00 AM and 9:53 AM, revealed no documentation for the Air leakage test for the dry pipe fire sprinkler system within the last 3 years. NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101, 9.7.1.1 (2012 Edition), NFPA 13, 24.6.1 (2010	K 353	1. On 10/02/2019 the Maintenance Director had Johnson Controls Company conduct the 3-year air leakage test for the Dry Pipe Fire Sprinkler System. On 10/02/2019 the Maintenance Director received a copy of the 3-year Full Flow Trip Test for the Dry Pipe Fire Sprinkler System that was completed on 4/23/2019 by Simplex Grinnell. On 10/02/2019 the Maintenance Director had Johnson Controls Company conduct the 10 year Dry Pendant Test for the Dry Pipe Fire Sprinkler System. On 10/02/2019 the Maintenance Director received a copy of the Annual Back Flow Inspection for the Fire Sprinkler System that was conducted on 2/25/2019 by Simplex Grinnell. 2. All residents had the potential to be affected, but no residents were affected. 3. On 9/24/2019 the Administrator and Director of Nursing educated the Maintenance Director and his assistant on the regulations pertaining to the sprinkler system. 4. Administrator and Maintenance Director will monitor compliance via the "Reqqer" System, Life Safety Monitoring Tool, and will ensure requirements are conveyed to the monthly QAPI meeting for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445172	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA NURSING AND REHABILITATION-SMITH COUNTY	112 HEALTH CARE DR CARTHAGE, TN 37030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 4 Edition), NFPA 25, 13.4.4.2.9 (2011 Edition) 2. Document review on 9/23/2019 between 9:00 AM and 9:53 AM, revealed no documentation for the full flow trip test for the dry pipe fire sprinkler system within the last 3 years. NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101, 9.7.1.1 (2012 Edition), NFPA 13, 24.6.1 (2010 Edition), NFPA 25, 13.4.4.2.2.2 (2011 Edition) 3. Document review on 9/23/2019 between 9:00 AM and 9:53 AM, revealed no documentation for the 10 year dry pendant test for the dry pipe fire sprinkler system. NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101, 9.7.1.1 (2012 Edition), NFPA 13, 24.6.1 (2010 Edition), NFPA 25, 5.3.1.1.1.6 (2011 Edition) 4. Document review on 9/23/2019 between 9:00 AM and 9:53 AM, revealed no backflow inspection for the fire sprinkler system within the last year. NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101, 9.7.1.1 (2012 Edition), NFPA 13, 24.6.1 (2010 Edition), NFPA 25, 13.3.3.1 (2011 Edition) The maintenance director was present for the findings which were later acknowledged by the administrator during the exit conference on 09/23/2019	K 353		
K 761 SS=D	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to	K 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445172	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA NURSING AND REHABILITATION-SMITH COUNTY	112 HEALTH CARE DR CARTHAGE, TN 37030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 5 patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to inspect protective openings. The finding included: Document review on 09/26/2019 between 9:00 AM and 9:53 AM, revealed no documentation for a fire damper inspection within the last 4 years. NFPA 101, 19.1.1.2 (2012 Edition), NFPA 101, 4.2.1 (2012 Edition), NFPA 101, 4.4.2.1 (2012 Edition), NFPA 101, 8.2.2.4 (2012 Edition), NFPA 80, 19.4.1.1 (2010 Edition) The maintenance director was present for the findings which were later acknowledged by the administrator during the exit conference on 09/23/2019	K 761	1. On 10/07/2019 the Maintenance Director had Cookeville Heating and Cooling Company conduct a 4-year Fire Damper Inspection Test. 2. All resident had the potential to be affected, but no residents were affected. 3. On 9/24/2019 the Administrator and Director of Nursing educated the Maintenance Director and his assistant on the regulations pertaining to Maintenance Inspection and Testing-Doors. 4. Administrator and Maintenance Director will assure compliance by using the "Reqqer" System, Life Safety Monitoring Tool and will ensure regulations are conveyed to the monthly QAPI meeting for 3 months.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445172	A. BUILDING _____ B. WING _____	09/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA NURSING AND REHABILITATION-SMITH COUNTY	112 HEALTH CARE DR CARTHAGE, TN 37030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments During the annual emergency preparedness survey conducted on 09/23/2019, no deficiencies were cited.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.